Claims Clues

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Reorganization Creates New FFS Division

The AHCCCS Administration has undergone a major reorganization designed to improve the agency's fee-for-service management, enhance its managed care business focus, and increase efficiency.

The reorganization involves three major changes:

- Creation of a single division -- the Division of Fee-For-Service Management -- that includes the clinical, administrative, and claims functions for acute and long term care fee-for-service activities. This division was created from units of the Office of Medical Management (OMM) and the Division of Business & Finance. The reorganization does ***not*** change any Claims Section policies and procedures, and providers should continue to submit fee-for-service claims to the AHCCCS Administration as in the past.
- Creation of a single division – the Division of Health Care Management -- that encompasses the clinical, administrative, and financial, functions for acute and long term care activities. This division integrates the former Office of Managed Care with units from OMM.
- Creation of a single unit – the Office of Community Relations – responsible for community relations, provider development, and Native American relationships. ❒

State Budget Eliminates Funds for SES Program

Funding for the State Emergency Services (SES) program, one of two AHCCCS programs limited to emergency services, was eliminated from the fiscal year 2004 state budget effective July 1, 2003.

The SES program was funded exclusively with state funds. It covered individuals who were either undocumented or non-qualified aliens who would not otherwise have qualified for the Federal Emergency Services (FES) program. Typically these were single adults.

The FES program was ***not*** affected by recent budget changes and will continue as it has in the past, covering the medical emergencies of undocumented individuals and non-qualified aliens. Typically this group includes children and pregnant women, as well as those who are aged, blind or disabled. The vast majority of emergency services only recipients qualify under the FES program.

Payment of claims for SES recipients for dates of service through June 30, 2003 is contingent upon continued availability of fiscal year 2003 state funds. (Hospital services for the SES population have not been eligible for reimbursement since March 2002 due to lack of funding.) Patients seen under the SES program on or after July 1, 2003 may be billed directly for any medical services provided, as they will no longer be covered by AHCCCS.

There may be community resources available for referral of these individuals for medical services. Federally Qualified Community Health Centers are one such resource. Certain other community clinics have sliding fee scale arrangements for persons of low income.

Providers who have questions should call the AHCCCS Division of Fee for Service Management at (602) 417-4241. ❒

Rates Adjusted for Injection Codes Q2008 and J3490

Two injection codes, earlier announced as rate updates for April 1, 2003, have received rate adjustments.

The rate for Q2008 (injection, fomepizole, 15 mg) is $10.89, effective for dates of service on and after April 1, 2003.

J3490 (unclassified drugs) will continue to be paid "By Report", effective for dates of service on and after March 1, 1989. A rate was set for this code in April, but it was later determined that the code should be paid "By Report." ❒

Hospitals May Bill Circumcision with V50.2; Charges Must Be Reported as Non-covered

Hospitals may bill newborn circumcisions with diagnosis code of V50.2 (Routine or ritual circumcision).

However, all related charges must be reported in the Non-covered Charges field (Field 48) of the UB-92 claim form. Claims without non-covered charges will be denied.

AHCCCS ended coverage of routine circumcision for newborn male infants on October 1, 2002. AHCCCS no longer covers CPT-4 codes 54150 (Circumcision, using clamp or other device; newborn) and 54160 (Circumcision, surgical excision other than clamp, device, or dorsal slit; newborn).

To report medically necessary circumcisions on the CMS 1500 claim form, the appropriate ICD-9 diagnosis code documenting medical necessity must be used. Physicians should bill either with CPT-4 code 54152 (Circumcision, using clamp or other device; other than newborn) or 54161 (Circumcision, surgical excision other than clamp, device, or dorsal slit; other than newborn).

Prior authorization must be obtained for fee-for-service recipients. ❒

Open Enrollment Likely to Tax Comm Center Phones; Providers Should Use Other Verification Processes

During the next few months, some 125,000 AHCCCS members will be selecting new health plans, and the Communications Center phones are expected to be very busy during this time period.

AHCCCS recently awarded contracts to seven acute care health plans, effective October 1. Members of plans that will not continue with AHCCCS or that did not receive contracts to serve in their current areas will have the opportunity to select new plans before October 1. The changes will affect more than 125,000 AHCCCS members who will have to select new plans.

The Communications Center's new business hours are from 6 a.m. through midnight. Verifications and newborn notifications will be taken by Comm Center staff during those hours. All automated verification systems (Medifax, IVR, and the Web) are available 24 hours a day.

The enrollment process is expected to generate a high volume of telephone calls to the Communications Center, making it difficult for providers to obtain eligibility and enrollment information from Comm Center staff.

Providers who need to verify eligibility and enrollment should use one of the following verification processes during this period. The options are listed in priority order.

- Internet

AHCCCS has developed a Web application that allows providers to verify eligibility and enrollment using the Internet.

To create an account and begin using the application, go to the AHCCCS Home Page at www.ahcccs.state.az.us. Click on the Information for Providers link to go to the Providers page. A link on the Providers page allows providers to create an account.

- Medical Electronic Verification System (MEVS)

MEVS uses "swipe card" technology to verify recipient eligibility and enrollment.

For information on MEVS, contact one of the MEVS vendors:

Envoy: 1-800-366-5716

Potomac Group: 1-800-444-4336

- Eligibility Verification System (EVS)

EVS, also known as Medifax, allows providers to use a PC or terminal to verify eligibility and enrollment.

For information on EVS, contact the Potomac Group at 1-800-444-4336

- Interactive Voice Response system (IVR)

IVR allows unlimited verifications by using a touch-tone telephone.

Providers may call IVR at:

Phoenix: (602) 417-7200

All others: 1-800-331-5090 ❒